Medtronic

2022 Billing and Coding Guide

Gynecology Surgery

Rates listed in this guide are based on their respective site of care- ambulatory surgical center or hospital outpatient department. All rates provided are for the Medicare unadjusted national average rounded to the nearest whole number for the calendar year and do not represent adjustment specific to the provider's location or facility. Commercial rates are based on individual contracts. Providers are encouraged to review contracts to verify their specific contracted allowables.

Medtronic products associated with wound closure procedures addressed within this guide do not have a dedicated HCPCS[1] Level II coding assignment. Providers may choose to report *A4649 Surgical supply; miscellaneous* for purposes of cost tracking. Medicare considers the use of surgical supplies to be included in the payment for the associated CPT©, and no additional payment is allowed.

CPT© Code[2]	Description	Physician[3]	Ambulatory Surgical Center[4]	Hospital Outpatient[4]
Hysterectomy				
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);	Facility Only: $1,040	Inpatient only, not reimbursed for hospital outpatient or ASC	
58152	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); with colpo-urethrocystopexy (e.g., Marshall- Marchetti-Krantz, Burch)	Facility Only: $1,275	Inpatient only, not reimbursed for hospital outpatient or ASC	
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)	Facility Only: $987	Inpatient only, not reimbursed for hospital outpatient or ASC	
58200	Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s)	Facility Only: $1,381	Inpatient only, not reimbursed for hospital outpatient or ASC	
58210	Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)	Facility Only: $1,869	Inpatient only, not reimbursed for hospital outpatient or ASC	
58240	Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), with removal of bladder and ureteral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination	Facility Only: $3,018	Inpatient only, not reimbursed for hospital outpatient or ASC	

CPT© Code[2]	Description	Physician[3]	Ambulatory Surgical Center[4]	Hospital Outpatient[4]
Hysterectomy Continued				
58260	Vaginal hysterectomy, for uterus 250 g or less;	Facility Only: $865	$1,910	$4,503
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)	Facility Only: $955	$1,910	$4,503
58263	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele	Facility Only: $1,024	N/A	$4,503
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele	Facility Only: $924	N/A	$4,503
58275	Vaginal hysterectomy, with total or partial vaginectomy;	Facility Only: $1,019	Inpatient only, not reimbursed for hospital outpatient or ASC	
58280	Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele	Facility Only:$1,093	Inpatient only, not reimbursed for hospital outpatient or ASC	
58285	Vaginal hysterectomy, radical (Schauta type operation)	Facility Only:$1,459	Inpatient only, not reimbursed for hospital outpatient or ASC	
58290	Vaginal hysterectomy, for uterus greater than 250 g;	Facility Only: $1,186	N/A	$6,933
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Facility Only: $1,282	N/A	$4,503
58292	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele	Facility Only: $1,351	N/A	$6,933
58294	Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele	Facility Only: $1,255	N/A	$4,503
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;	Facility Only: $752	$2,363	$5,168
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Facility Only: $857	$3,890	$9,096
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;	Facility Only: $869	$3,890	$9,096
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Facility Only: $933	$3,890	$9,096
58548	Laparoscopy, surgical, with radical hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with removal of tube(s) and ovary(s), if performed	Facility Only: $1,931	Inpatient only, not reimbursed for hospital outpatient or ASC	
58550	Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 g or less;	Facility Only: $907	$2,363	$5,168

CPT© Code[2]	Description	Physician[3]	Ambulatory Surgical Center[4]	Hospital Outpatient[4]
58552	Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Facility Only: $1,008	$3,890	$9,096
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g;	Facility Only: $1,152	$3,890	$9,096
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Facility Only: $1,341	$3,890	$9,096
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;	Facility Only: $829	$3,890	$9,096
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;	Facility Only:$934	$3,890	$9,096
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g	Facility Only:$1,066	$3,890	$9,096
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Facility Only:$1,251	$3,890	$9,096
Myomectomy				
58545	Laparoscopy, surgical, myomectomy, excision; 1 to 4 intramural myomas with total weight of 250 g or less and/or removal of surface myomas	Facility Only: $927	$2,363	$5,168
58546	Laparoscopy, surgical, myomectomy, excision; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 g	Facility Only: $1,146	$3,890	$9,096
Oophorectomy				
58920	Wedge resection or bisection of ovary, unilateral or bilateral	Facility Only: $738	NA	$6,933
58940	Oophorectomy, partial or total, unilateral or bilateral;	Facility Only: $575	Inpatient only, not reimbursed for hospital outpatient or ASC	
58943	Oophorectomy, partial or total, unilateral or bilateral; for ovarian, tubal or primary peritoneal malignancy, with para-aortic and pelvic lymph node biopsies, peritoneal washings, peritoneal biopsies, diaphragmatic assessments, with or without salpingectomy(s), with or without omentectomy	Facility Only: $1,202	Inpatient only, not reimbursed for hospital outpatient or ASC	
58953	Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking;	Facility Only: $2,051	Inpatient only, not reimbursed for hospital outpatient or ASC	
58954	Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking; with pelvic lymphadenectomy and limited para-aortic lymphadenectomy	Facility Only: $2,219	Inpatient only, not reimbursed for hospital outpatient or ASC	

CPT© Code[2]	Description	Physician[3]	Ambulatory Surgical Center[4]	Hospital Outpatient[4]
58956	Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy for malignancy	Facility Only: $1,394	Inpatient only, not reimbursed for hospital outpatient or ASC	
Tubal Ligation				
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	Facility Only: $382	$1,331	$2,680
58605	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)	Facility Only: $349	Inpatient only, not reimbursed for hospital outpatient or ASC	
58611	Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)	Facility Only: $78	Inpatient only, not reimbursed for hospital outpatient or ASC	
58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach	Facility Only: $263	$1,331	$2,680
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)	Facility Only: $384	$2,363	$5,168
58671	Laparoscopy, surgical; with occlusion of oviducts by device (e.g., band, clip, or Falope ring)	Facility Only: $383	$2,363	$5,168
S2900	Surgical techniques requiring use of robotic surgical system (list separately in addition to code for primary procedure)	HCPCS II S-Codes cannot be reported to Medicare. They are used only by non-Medicare payers, which may cover and price them according to their own requirements		

Hospital Inpatient Procedure Coding for OB/GYN Surgery

ICD-10-PCS procedure codes[5] are used by hospitals to report surgeries and procedures performed in the inpatient setting. All ICD-10-PCS codes have seven digits, each digit representing a specific character associated with procedures. Code assignment in ICD-10-PCS is a process of "constructing" the code by selecting values from a code table for each of the seven standard characters. Key characters are discussed below.

Character	Description
3: Root Operation	The two main root operations for removal of tissue are B-Excision and T-Resection. By definition, B-Excision involves removing a portion of the body part and T-Resection involves removing the entire body part. For tubal ligation i.e. sterilization, the root operation depends on the technique: B-Excision is used for removal of a" knuckle" of the fallopian tube 5-Destruction is used for fulguration and cautery L-Occlusion is used for ligation and division as well as for placement of devices such as rings and clips Note that physicians may use these terms more broadly. It is the coder's responsibility to determine what the physician's documentation equates to in terms of ICD-10-PCS definitions. The physician is not expected to document using ICD-10-PCS code descriptions.[2]
4: Body Part	Because each body part is identified distinctly, separate codes are assigned for uterus (i.e. corpus), cervix, ovary, and fallopian tube. This means that many common OB/GYN surgeries require two or more codes. For example, ICD-10-PCS requires that two codes be assigned for a total hysterectomy: one removing the uterus and one code for removing the cervix. Similarly, for a total hysterectomy with bilateral salpingo-oophorectomy, four codes must be assigned: one each for removing the uterus, cervix, the ovaries, and the fallopian tubes.
5: Approach	Different codes are constructed depending on the approach: 0-Open involves an open incision to directly expose the surgical site 4-Percutaneous Endoscopic is used for procedures performed via laparoscopy 7-Via Natural or Artificial Opening, e.g. vaginal hysterectomy F-Via Natural or Artificial Opening with Percutaneous Endoscopic Assistance, e.g., laparoscopically assisted vaginal hysterectomy

ICD-10-PCS Code[5]	Code Description
Hysterectomy	
Additional codes are assigned for removal of ovaries and fallopian tubes.	
Supracervical or Subtotal Hysterectomy (excision of uterus without cervix)	
0UT90ZZ	Resection of uterus, open approach
0UT94ZZ	Resection of uterus, percutaneous endoscopic approach
Total Abdominal Hysterectomy, Open (TAH)	
0UT90ZZ	Resection of uterus, open approach
plus	
0UTC0ZZ	Resection of cervix, open approach
Total Hysterectomy, Laparoscopic (LVH)	
0UT94ZZ	Resection of uterus, percutaneous endoscopic approach
Plus	
0UTC4ZZ	Resection of cervix, percutaneous endoscopic approach
Total Vaginal Hysterectomy (TVH)	
0UT97ZZ	Resection of uterus, via natural or artificial opening
plus	
0UTC7ZZ	Resection of cervix, via natural or artificial opening
Laparoscopically Assisted Vaginal Hysterectomy (LAVH)	
0UT9FZZ	Resection of uterus, via natural or artificial opening with percutaneous endoscopic assistance
Plus	
0UTC7ZZ	Resection of cervix, via natural or artificial opening
Radical Hysterectomy	
Radical hysterectomy involves removal of the uterus, cervix, ovaries and fallopian tubes as well as removal of uterine supporting structures (e.g., ligaments), removal of the vagina, and/or extensive pelvic and aortic lymphadenectomy. Hysterectomy is coded as above. optional codes are then assigned to capture removal of uterine supporting structures and vagina, and lymphadenectomy as performed.	
Myomectomy	
0UB90ZZ	Excision of uterus, open approach
0UB94ZZ	Excision of uterus, percutaneous endoscopic approach
Oophorectomy and Salpingectomy	
Excision of Ovarian Lesion, Wedge Resection	
0UB00ZZ	Excision of right ovary, open approach
0UB04ZZ	Excision of right ovary, percutaneous endoscopic approach
0UB10ZZ	Excision of left ovary, open approach
0UB14ZZ	Excision of left ovary, percutaneous endoscopic approach
0UB20ZZ	Excision of bilateral ovaries, open approach
0UB24ZZ	Excision of bilateral ovaries, percutaneous endoscopic approach
Complete Oophorectomy	
0UT00ZZ	Resection of right ovary, open approach
0UT04ZZ	Resection of right ovary, percutaneous endoscopic approach
0UT10ZZ	Resection of left ovary, open approach
0UT14ZZ	Resection of left ovary, percutaneous endoscopic approach
0UT20ZZ	Resection of bilateral ovaries, open approach
0UT24ZZ	Resection of bilateral ovaries, percutaneous endoscopic approach

ICD-10-PCS Code[5]	Code Description
Complete Salpingectomy	
0UT50ZZ	Resection of right fallopian tube, open approach
0UT54ZZ	Resection of right fallopian tube, percutaneous endoscopic approach
0UT60ZZ	Resection of left fallopian tube, open approach
0UT64ZZ	Resection of left fallopian tube, percutaneous endoscopic approach
0UT70ZZ	Resection of bilateral fallopian tubes, open approach
0UT74ZZ	Resection of bilateral fallopian tubes, percutaneous endoscopic approach
Tubal Ligation	
0U570ZZ	Destruction of bilateral fallopian tubes, open approach
0U574ZZ	Destruction of bilateral fallopian tubes, percutaneous endoscopic approach
0UB70ZZ	Excision of bilateral fallopian tubes, open approach
0UB74ZZ	Excision of bilateral fallopian tubes, percutaneous endoscopic approach
0UL70ZZ	Occlusion of bilateral fallopian tubes, open approach
0UL74ZZ	Occlusion of bilateral fallopian tubes, percutaneous endoscopic approach
Robotic Assistance	
Codes for robotic assistance are assigned separately in addition to the primary procedure code.	
8E0W0CZ	Robotic assisted procedure of trunk region, open approach
8E0W4CZ	Robotic assisted procedure of trunk region, percutaneous endoscopic approach

Hospital Inpatient DRG's for OB/GYN Surgery

DRG Assignment FY2022—effective October 1, 2021

Under Medicare's MS-DRG methodology for hospital inpatient payment, each inpatient stay is assigned to one of about 750 diagnosis-related groups, based on the ICD-10 codes assigned to the diagnoses and procedures. Only one MS-DRG is assigned for each inpatient stay, regardless of the number of procedures performed. MS- DRGs shown are those typically assigned to the following scenarios when the patient is admitted specifically for the procedure.

MS-DRG[6]	Description	FY 2022 Payment
HYSTERECTOMY DRGs 734, 735 for Radical Hysterectomy require the presence of additional codes for removal of uterine supporting structures (e.g., ligaments) and/or extensive pelvic and aortic lymphadenectomy.		
734	Pelvic Evisceration, Radical Hysterectomy and Radical Vulvectomy W CC/MCC	$14,668
735	Pelvic Evisceration, Radical Hysterectomy and Radical Vulvectomy W/O CC/MCC	$9,322
736	Uterine and Adnexa Procedures for Ovarian or Adnexal Malignancy W MCC	$28,096
737	Uterine and Adnexa Procedures for Ovarian or Adnexal Malignancy W CC	$13,572
738	Uterine and Adnexa Procedures for Ovarian or Adnexal Malignancy W/O CC/MCC	$9,732
739	Uterine, Adnexa Procedures for Non-Ovarian/Adnexal Malignancy W MCC	$25,216
740	Uterine, Adnexa Procedures for Non-Ovarian/Adnexal Malignancy W CC	$11,880
741	Uterine, Adnexa Procedures for Non-Ovarian/Adnexal Malignancy W/O CC/MCC	$8,440
742	Uterine and Adnexa Procedures for Non-Malignancy W CC/MCC	$11,330
743	Uterine and Adnexa Procedures for Non-Malignancy W/O CC/MCC	$7,470
MYOMECTOMY - Myomectomy is typically performed for non-malignant lesions, e.g., fibroids.		
742	Uterine and Adnexa Procedures for Non-Malignancy W CC/MCC	$11,330
743	Uterine and Adnexa Procedures for Non-Malignancy W/O CC/MCC	$7,470
Oophorectomy and Salpingectomy		
736	Uterine and Adnexa Procedures for Ovarian or Adnexal Malignancy W MCC	$28,096
737	Uterine and Adnexa Procedures for Ovarian or Adnexal Malignancy W CC	$13,572
738	Uterine and Adnexa Procedures for Ovarian or Adnexal Malignancy W/O CC/MCC	$9,732
739	Uterine, Adnexa Procedures for Non-Ovarian/Adnexal Malignancy W MCC	$25,216
740	Uterine, Adnexa Procedures for Non-Ovarian/Adnexal Malignancy W CC	$11,880
741	Uterine, Adnexa Procedures for Non-Ovarian/Adnexal Malignancy W/O CC/MCC	$8,440
742	Uterine and Adnexa Procedures for Non-Malignancy W CC/MCC	$11,330
743	Uterine and Adnexa Procedures for Non-Malignancy W/O CC/MCC	$7,470
Tubal Ligation		
744	D&C, Conization, Laparoscopy and Tubal Interruption W CC/MCC	$11,839
745	D&C, Conization, Laparoscopy and Tubal Interruption W/O CC/MCC	$7,715

[1]Centers for Medicare & Medicaid Services. Alpha-numeric HCPCS. https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update

[2] CPT copyright 2021 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

[3]Centers for Medicare and Medicaid Services. Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Federal Register (86 Fed. Reg. No. 221 64996-66031) https://www.govinfo.gov/content/pkg/FR-2021-11-19/pdf/2021-23972.pdf Published November 19, 2021. Physician Fee Schedule – January 2022 Release. https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-relative-value-files/rvu22a

[4]Centers for Medicare and Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Final Rule, Federal Register (86 Fed. Reg. No.218 63458-63477), https://www.govinfo.gov/content/pkg/FR-2021-11-16/pdf/2021-24011.pdf Published November 16, 2021. ASC Payment Rates – Addenda January 2022 ASC Approved HCPCS Code and Payment Rates-Updated January 4, 2022. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates

[5]Department of Health and Human Services, Centers for Medicare & Medicaid Services. International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS). https://www.cms.gov/medicare/icd-10/2022-icd-10-cm

[6]Centers for Medicare and Medicaid Services. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the LongTerm Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2022 Rates; Final Rule, Federal Register (86 Fed. Reg. No. 154 44774-45615), https://www.govinfo.gov/content/pkg/FR-2021-08-13/pdf/2021-16519.pdf Published August 13, 2021.

Medtronic provides this information for your convenience only. It does not constitute legal advice or a recommendation regarding clinical practice. Information provided is gathered from third-party sources and is subject to change without notice due to frequently changing laws, rules and regulations. The provider has the responsibility to determine medical necessity and to submit appropriate codes and charges for care provided. Medtronic makes no guarantee that the use of this information will prevent differences of opinion or disputes with Medicare or other payers as to the correct form of billing or the amount that will be paid to providers of service. Please contact your Medicare contractor, other payers, reimbursement specialists and/or legal counsel for interpretation of coding, coverage and payment policies. This document provides assistance for FDA approved or cleared indications. Where reimbursement is sought for use of a product that may be inconsistent with, or not expressly specified in, the FDA cleared or approved labeling (e.g., instructions for use, operator's manual or package insert), consult with your billing advisors or payers on handling such billing issues. Some payers may have policies that make it inappropriate to submit claims for such items or related service.